Marshy Hope Family Services, LLC
813-1 Chesapeake Drive
Cambridge, MD 21613

Patient: _____
Last Name First Name Middle Initial

Address: _____
Street Apt. No. City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone _____
*May a message regarding appointments and medications be left with household members or answering machine? Y___N___

Sex: ___M___F Age:____ Birthdate:_____ Marital Status:_____ SSN:_____

Race: ___AA ___W ___AS ___O ___Hispanic __Employed ___Full-time Student ___Part-time Student

Unemployed/School/Employer: _____
Drug Allergies/Reactions (if any): _____

Primary Care Physician (Name and Phone Number): _____

Parent/Spouse: _____ DOB:_____ SSN:_____
Last Name First Name

Parent/Spouse: _____ DOB:_____ SSN:_____
Last Name First Name

Parent/Spouse Employer: _____ Business Phone: _____

Name of Insured: _____ DOB:_____ SSN:_____
TYPE OF INSURANCE:
Primary: _____
Name of Insurance Membership # Group #

Secondary: _____
Name of Insurance Membership # Group #

All professional services are charged to the patient. Necessary forms will need to be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance.

Insurance authorization and assignment (staff write in Beacon Health Options if gray zone)

Name of Policy Holder: _____ Policy Number: _____ Exp. Date: _____
I request that payment of authorized Medicare/Other Insurance Company benefits be made to me or on my behalf to Marshy Hope Family Services, LLC for any services furnished me by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurance or agency shown. In Medicare/Other Insurance Company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance Company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance Company. I authorized the release of information to Beacon Health Options and the local Core Service Agency if I am a Medical Assistance or Gray Zone client, for the purpose of coordinating appropriate services.
SIGNATATURE: _____ DATE: _____

Are you a U.S. Citizen? Circle: YES NO

Email Address: _____
Would you like to be contacted by email when available? Yes No

EMERGENCY CONTACTS:

Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone or Business Phone:_____

Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone or Business Phone:_____

IF PATIENT IS UNDER THE AGE OF EIGHTEEN A THIRD EMERGENCY CONTACT IS REQUIRED.

Name:_____ Relationship to Patient:_____

Home Phone:_____ Cell Phone or Business Phone:_____

ADDITIONAL CONTACTS:

School Name:_____ Phone Number:_____

School Address:_____ Fax Number:_____

School Contact:_____ Phone Number:_____
Fax Number: _____

School Nurse's Name:_____ Phone Number:_____
Fax Number:_____

Wellness Center:_____ Phone Number:_____
Fax Number:_____

Contact Name:_____

Address:_____

Pharmacy: 1._____ Phone:_____ Fax:_____

2. ._____ Phone:_____ Fax:_____

Staff Instructions:
Releases must be obtained for Primary Care Physicians, School, and both Emergency Contacts. If the patient is under the age of Eighteen you must obtain a third emergency contact.